STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 00 B. WING	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

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F0000	This visit was for the investigation of complaint IN00110319. Complaint IN00110319- Substantiated with Federal/State deficiencies related to the allegations cited at F-225, F-226, and F-309. Survey date: 6/21/12 Facility number: 000498 Provider number: 155654 AIM number: 100266110 Survey team: Tim Long, RN-TC Susie Scott, RN Julie Wagoner, RN Christine Fodrea, RN Census bed type: SNF/NF: 61 Total: 61 Census Payor type: Medicare: 2 Medicaid: 46 Other: 13 Total: 61 Sample: 3	F0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 25, 2012 by Bev Faulkner, RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the	F0225	The facility is unable to correct the alleged deficient practice for resident C as it occurred in the	07/21/2012

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	facility failed to ensure residents were protected from potential further abuse during an investigation of abuse and failed to thoroughly document the investigation for 1 of 3 residents (Resident C) reviewed for abuse. Findings include: Resident C's clinical record was reviewed on 6/21/12 at 9:30 A.M. The record indicated on 1/6/12 at 12:30 A.M., an incident occurred in which the resident indicated CNA #1 treated her roughly during cleaning her up after using the bed pan. Review of a facility incident report from 1/6/12 at 1:30 P.M., indicated "Resident stated to LPN on the night shift that the CNA had wiped her too hard when cleaning her up from using the bed pan." The immediate action taken was the LPN had the other CNA that was working take over providing care for Resident C and notified the DON. The preventive measures taken were: "Investigation initiated. Social Services notified. Conclusion: Allegation was found to be unsubstantiated. Preventive Measures: will have CNA in question no longer care for above stated resident, and we will have 2 staff members to care for resident with activities of daily living."		past. All residents have the potential to be affected by the alleged deficient practice. Alert residents and family members will be interviewed to ensure no other residents have been affected by the alleged deficient practice. Resident and family member interviews will continue for 15 residents at random every three months ongoing. Administrator to audit interviews after completion. Audit results to be discussed at QA Committee meetings. Staffing rein-service conducted 6/26/12 on facility abuse policy and the Indiana Reportable Unusual Occurrence Guidelines. ADDENDUM:1. Staff inservice held 6/26/12 instructing nursing to notify HFA immediately with any allegations of abuse. HFA will ensure Preliminary Investigation is initiated, which includes a task of immediate suspension of alleged employee pending investigation.2. The Internal Investigation Report shall be updated to include all areas of investigation have been completed according to policy.	

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	The facility documentation of the investigation of the incident of 1/6/12 involving Resident C and CNA #1 included a statement by LPN #2 who indicated the resident stated to her CNA #1 got the resident off the bed pan and wiped her buttocks too hard. The resident also indicated she didn't feel comfortable with the aide wiping her because she felt more of the aide's fingers than tissue. The resident stated she didn't have a bowel movement and didn't need or want wiped. LPN #2 indicated she spoke with CNA #1 who indicated Resident C had a bowel movement and needed to be cleaned up. The facility documentation of the investigation of the incident of 1/6/12 involving Resident C also contained an internal investigation report by the Director of Nursing (DN) which indicated the DN interviewed the resident on 1/6/12 at 7:30 A.M. The resident stated: "The CNA was cleaning her up from using the bed pan and that she had only urinated, but the CNA wiped around her rectal area and she then went on to state she felt his finger enter her rectum and then he did it a second time and she felt he did it on purpose." The facility investigation included interviews with two alert and oriented			

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	residents on the unit on which CNA #1 was working at the time of the incident of 1/6/12. The facility investigation also indicated they spoke with other alert and oriented residents on the hallway and spoke with other staff concerning the allegation. The investigation did not include names of any of the other residents or staff. CNA #1 was not suspended immediately after LPN #1 was made aware of the accusation on 1/6/12. CNA #1 was allowed to work with other residents in the facility on 1/6/12. CNA #1 was not suspended during the investigation of the allegation of abuse on 1/6/12. The facility incident reporting form was faxed to ISDH on 1/6/12 at 1:30 P.M. The follow-up investigation was faxed to ISDH on 1/6/12 at 3:30 P.M., indicating the allegation of abuse was unsubstantiated. An interview with the resident on 6/21/12 at 2:15 P.M., indicated the resident was sure CNA #1 put his finger up into her rectum. Resident C indicated she was not afraid of CNA #1 because they always have two people to do her care since the incident of 1/6/12. This Federal Tag relates to Complaint IN00110319.			

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	3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy for abuse related to assessment of a resident and protection of the resident following an allegation of abuse for 1 of 3 residents (C) reviewed for abuse. Findings include: Resident C's clinical record was reviewed on 6/21/12 at 9:30 A.M. The record indicated on 1/6/12 at 12:30 A.M., an incident occurred in which the resident indicated CNA #1 treated her roughly during cleaning her up after using the bed pan. Review of a facility incident report from 1/6/12 at 1:30 P.M., indicated "Resident stated to LPN on the night shift that the CNA had wiped her too hard when cleaning her up from using the bed pan." The immediate action taken was the LPN had the other CNA that was working take over providing care for Resident C and notified the DON. The preventive	F0226	The facility is unable to correct the alleged deficient practice for resident C as it occurred in the past. All residents have the potential to be affected by the alleged deficient practice. Alert residents and family members will be interviewed to ensure no other residents have been affected by the alleged deficient practice. Resident and family member interviews will continue for 15 residents at random every three months ongoing. Administrator to audit interviews after completion. Audit results to be discussed at QA Committee meetings. Staff rein-service to be conducted on facility abuse procedures and investigative guidelines. ADDENDUM:1. An abuse policy checklist will be intiated for all nurses to utlilize when an allegation of abuse occurs.	07/21/2012

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	measures taken were: "Investigation initiated. Social Services notified. Conclusion: Allegation was found to be unsubstantiated. Preventive Measures: will have CNA in question no longer care for above stated resident, and we will have 2 staff members to care for resident with activities of daily living." The facility documentation of the investigation of the incident of 1/6/12 involving Resident C and CNA #1 included a statement by LPN #2 who indicated the resident stated to her CNA #1 got the resident off the bed pan and wiped her buttocks too hard. The resident also indicated she didn't feel comfortable with aide wiping her because she felt more of the aide's fingers than tissue. The resident stated she didn't have a bowel movement and didn't need or want wiped. LPN #2 indicated she spoke with CNA #1 who indicated Resident C had a bowel movement and needed to be cleaned up. The facility documentation of the investigation of the incident of 1/6/12 involving Resident C also contained an internal investigation report by the Director of Nursing (DN) which indicated the DN interviewed the resident on 1/6/12 at 7:30 A.M. The resident stated: "The CNA was cleaning her up from using the bed pan and that she had only urinated,			

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	but the CNA wiped around her rectal area and she then went on to state she felt his finger enter her rectum and then he did it a second time and she felt he did it on purpose." The facility investigation included interviews with two alert and oriented residents on the unit on which CNA #1 was working at the time of the incident of 1/6/12. The facility investigation also indicated they spoke with other alert and oriented residents on the hallway and spoke with other staff concerning the allegation. The investigation did not include names of any of the other residents or staff. No documentation was noted of a physical exam of the resident after the allegation or any type of examination was completed of the resident after the incident on 1/6/12. CNA #1 was not suspended immediately after LPN #1 was made aware of the accusation on 1/6/12. CNA #1 was allowed to work with other residents in the facility on 1/6/12. CNA #1 was not suspended during the investigation of the allegation of abuse on 1/6/12. The facility incident reporting form was faxed to ISDH on 1/6/12 at 1:30 P.M. The follow-up investigation was faxed to			

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	ISDH on 1/6/12 at 3:30 P.M., indicating the allegation of abuse was unsubstantiated. An interview with the resident on 6/21/12 at 2:15 P.M., indicated the resident was sure CNA #1 put his finger up into her rectum. Resident C indicated she was not afraid of CNA #1 because they always have 2 people to do her care since the incident of 1/6/12. Review of the facility policy, "Abuse, Neglect, Misappropriation of Resident Property, dated 1/2012 under Policy Interpretation and Implementation included: "Section 8. All residents will be assessed immediately by the attending nurse upon notification of alleged abuse, neglect, or mistreatment." "Section 10. b." indicated: "If the resident sustains injury by an employee or employee is a suspected perpetrator: ...iii. employee must be sent home (suspended) immediately pending outcome of final investigation". This Federal Tag relates to Complaint IN00110319 3.1-28(a)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to complete a physical assessment following an allegation of abuse for 1 resident (Resident C) of 3 residents reviewed for abuse. Findings include: Resident C's clinical record was reviewed on 6/21/12 at 9:30 A.M. The record indicated on 1/6/12 at 12:30 A.M., an incident occurred in which the resident indicated CNA #1 treated her roughly during cleaning her up after using the bed pan. Review of a facility incident report from 1/6/12 at 1:30 P.M., indicated "Resident stated to LPN on the night shift that the CNA had wiped her too hard when cleaning her up from using the bed pan." The immediate action taken was the LPN had the other CNA that was working take over providing care for Resident C and notified the DON.	F0309	The facility is unable to correct the alleged deficient practice for resident C as it occurred in the past. All residents have the potential to be affected by the alleged deficient practice. Alert residents and family members will be interviewed to ensure no other residents have been affected by the alleged deficient practice. Resident and family member interviews will continue for 15 residents at random every three months ongoing. Administrator to audit interviews after completion. Audit results to be discussed at QA Committee meetings. Staff rein-service to be conducted on facility abuse procedures and investigative guidelines. ADDENDUM:1. Abuse policy checklist will include a physical resident assesment task.	07/21/2012

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	sure CNA #1 put his finger up into her rectum. Resident C indicated she was not afraid of CNA #1 because they always have two people to do her care since the incident of 1/6/12. No documentation was noted of a physical exam of the resident after the allegation or any type of examination was completed of the resident after the incident on 1/6/12. Review of the facility policy "Abuse, Neglect, and Misappropriation of Resident's Property" from 01/2012 under section "Policy Interpretation and Implementation," included "Section 8: All residents will be assessed immediately by the attending nurse upon notification of alleged abuse, neglect or mistreatment." This Federal Tag relates to Complaint IN00110319. 3.1-37(a)			